



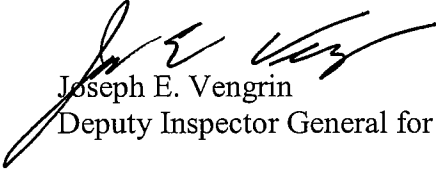
DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR - 5 2007

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: 
Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Medicaid Community Mental Health Center Provider Services
in Indiana (A-05-05-00057)

Attached is an advance copy of our final report on Medicaid community mental health center provider services in Indiana for Federal fiscal year 2003. We will issue this report to the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (Indiana) within 5 business days.

Indiana elected to include optional Medicaid coverage for medical or remedial "rehabilitative services" that are provided by community mental health centers (CMHC) in an individual or group setting. These services are recommended by physicians or other licensed practitioners under a State program referred to as the Medicaid Rehabilitation Option (MRO) services program for, as the the Social Security Act specifies it, "... the maximum reduction of physical or mental disability and the restoration of an individual to the best possible functional level." For Federal fiscal year 2003, Indiana paid CMHC providers about \$226.5 million in total Medicaid reimbursement for MRO services.

Our objective was to determine whether the MRO services were provided by qualified staff, were adequately documented, and were accurately paid on behalf of eligible beneficiaries.

Based on a statistical projection of sample results, we estimate that Indiana overpaid CMHC providers at least \$33,407,323 (\$21,298,841 Federal share) in reimbursement for services provided during fiscal year 2003. We found that 64 of 200 randomly selected MRO services provided by CMHCs included one or more payment errors. The payment errors occurred because the services did not meet the Federal and State reimbursement requirements for rehabilitation services. Indiana did not have adequate internal controls to monitor the providers to ensure that rehabilitation services were in compliance with the "State Medicaid Manual" and Federal regulations.

We recommend that Indiana:

- refund \$21,298,841 to the Federal Government and
- strengthen internal controls over the monitoring of MRO services by furnishing written notification to CMHC providers reminding them to prepare and retain complete documentation to fully support Federal and State claiming provisions.

In written comments on our draft report, Indiana agreed with our second recommendation and partly agreed with our first recommendation. Indiana submitted additional information and requested reconsideration of specific claims. We analyzed the additional documentation and determined that the majority of documentation had been reviewed during fieldwork. However, based on our review of Indiana's response, we accepted six services and revised the projected refund and final report as appropriate.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov, or Marc Gustafson, Regional Inspector General for Audit Services, Region V, at (312) 353-2618 or through e-mail at Marc.Gustafson@oig.hhs.gov. Please refer to report number A-05-05-00057.

Attachment



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

APR - 9 2007

Report Number: A-05-05-00057

Ms. Jeanne M. LaBrecque
Director of Health Policy and Medicaid
Office of Medicaid Policy and Planning
Indiana Family and Social Services Administration
402 West Washington Street
Indianapolis, Indiana 46204-2739

Dear Ms. LaBrecque:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Medicaid Community Mental Health Center Provider Services in Indiana." A copy of this report will be forwarded to the action official noted on the next page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public law 104-231, OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-05-05-00057 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Marc Gustafson", is written over a horizontal line.

Marc Gustafson
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICAID COMMUNITY
MENTAL HEALTH CENTER
PROVIDER SERVICES IN INDIANA**



Daniel R. Levinson
Inspector General

April 2007
A-05-05-00057

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

Medicaid Clinic and Rehabilitative Services

Clinic and rehabilitative services furnished by community mental health centers (CMHC) may qualify for Medicaid coverage under Title XIX of the Social Security Act (the Act). Section 1905(a)(9) of the Act authorizes “clinic services” that are provided or directed by a physician. Regulations (42 CFR § 440.90) define clinic services as “. . . preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients.” Section 1905(a)(13) of the Act allows optional Medicaid coverage for medical or remedial “rehabilitative services” that are recommended by physicians or other licensed practitioners and provided “. . . for the maximum reduction of physical or mental disability and the restoration of an individual to the best possible functional level.” Indiana elected to include this optional Medicaid coverage under a State program referred to as the Medicaid Rehabilitation Option (MRO) services program.

Under the MRO services program, clinical mental health services are provided to individuals, families, or groups living in the community who need aid intermittently for emotional disturbances or mental illness. These services are designed to assist in developing the patient’s optimum functional ability in daily living activities, which is accomplished through a series of assessments and counseling or psychotherapy sessions. CMHCs provide these services in an individual or group setting.

The total Medicaid reimbursement paid by Indiana to CMHCs for MRO services includes a Federal share and a non-Federal share. For Federal fiscal year 2003, Indiana paid CMHC providers about \$226.5 million in total Medicaid reimbursement for MRO services. The Federal share of the reimbursement was about \$144 million, and the non-Federal share was about \$82.5 million.

OBJECTIVE

Our objective was to determine whether the MRO services were provided by qualified staff, were adequately documented, and were accurately paid on behalf of eligible beneficiaries.

SUMMARY OF FINDINGS

Based on a statistical projection of sample results, we estimate that Indiana overpaid CMHC providers at least \$33,407,323 (\$21,298,841 Federal share) in reimbursement for services provided during fiscal year 2003. Of 200 randomly selected MRO services provided by CMHCs, 64 included one or more payment errors. The errors occurred because the services did not meet Federal and State reimbursement requirements for rehabilitation services. Indiana did not have adequate internal controls to monitor the providers to ensure that rehabilitation services were in compliance with the “State Medicaid Manual” and Federal regulations.

The 64 services included 65 errors, as follows:

- missing or incomplete documentation for services (58 errors),
- services paid incorrectly by the State's fiscal agent (5 errors),
- ineligible service (1 error), and
- service by a provider who lacked proper credentials (1 error).

RECOMMENDATIONS

We recommend that Indiana:

- refund \$21,298,841 to the Federal Government and
- strengthen internal controls over the monitoring of MRO services by furnishing written notification to CMHC providers reminding them to prepare and retain complete documentation to fully support Federal and State claiming provisions.

INDIANA'S COMMENTS

In written comments on our draft report, Indiana agreed with our second recommendation and partly agreed with our first recommendation. Indiana submitted additional information and requested further reconsideration of specific claims. Indiana's comments are included as Appendix B.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We analyzed the additional documentation and determined that the majority of the documentation had been reviewed during fieldwork. However, based on our review of Indiana's comments, we accepted six services—four documentation errors and two ineligible services—and revised the projected refund and final report as appropriate.

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INTRODUCTION

BACKGROUND

Medicaid Program

Title XIX of the Social Security Act (the Act) established the Medicaid program as a jointly funded Federal and State program to provide medical assistance to qualified low-income persons. Each State administers its Medicaid program in accordance with a State plan approved by the Centers for Medicare & Medicaid Services, which is responsible for the program at the Federal level. In Indiana, the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (Indiana) administers the Medicaid program.

Within broad Federal rules, each State determines eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Federal funds are available to match expenditures under the Medicaid State plan.

Medicaid Rehabilitation Services

Clinic and rehabilitative services furnished by community mental health centers (CMHC) may qualify for Medicaid coverage. Section 1905(a)(9) of the Act authorizes “clinic services” that are provided or directed by a physician. Federal regulations (42 CFR § 440.90) define clinic services as “. . . preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients.”

Section 1905(a)(13) of the Act authorizes optional medical or remedial “rehabilitative services” that are recommended by physicians or other licensed practitioners and are provided “. . . for the maximum reduction of physical or mental disability and the restoration of an individual to the best possible functional level.” Indiana elected to include this optional Medicaid coverage under a State program referred to as the Medicaid Rehabilitation Option (MRO) services program.

Indiana Medicaid Rehabilitation Option

Under the MRO services program, clinical mental health services are provided to individuals, families, or groups living in the community who need aid intermittently for emotional disturbances or mental illness. These services are designed to assist in developing the patient’s optimum functional ability in daily living activities, which is accomplished through a series of assessments and counseling or psychotherapy sessions. CMHCs provide these services in an individual or group setting.

Rehabilitation services for Medicaid beneficiaries are described in the State plan under “Community Mental Health Rehabilitation Services.” Services include outpatient mental health services, partial hospitalization services, and case management services.

State Regulations and Reimbursement Mechanism

The Indiana Administrative Code (IAC) (405 IAC 5-21-2) provides that “Medicaid will reimburse the costs for community mental health services for persons with mental illness when those services are provided through a mental health center that is an enrolled Medicaid provider and that meets applicable Federal, State, and local laws concerning the operation of [CMHCs].” In addition, the IAC (405 IAC 5-21-3(a)) states that “the services reimbursable as outpatient mental health services are clinical mental health services that are provided to individuals, families, or groups of persons who are living in the community and who need aid on an intermittent basis for emotional disturbances or mental illness.”

The total Medicaid reimbursement paid by Indiana to CMHCs for MRO services includes a Federal share and a non-Federal share. For Federal fiscal year (FY) 2003, Indiana paid CMHC providers about \$226.5 million in total Medicaid reimbursement for MRO services. The Federal share of the reimbursement was about \$144 million, and the non-Federal share was about \$82.5 million.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the MRO services were provided by qualified staff, were adequately documented, and were accurately paid on behalf of eligible beneficiaries.

Scope

Our audit covered MRO services provided during FY 2003.

The scope of our audit did not include a medical review or an evaluation of the medical necessity for the services. In addition, we did not evaluate the appropriateness of the fund transfers used by Indiana to cover the non-Federal share of the total Medicaid reimbursement. Our review of internal controls was limited to obtaining an understanding of those controls that pertained directly to the MRO services program.

We performed our fieldwork at Indiana’s offices in Indianapolis and at various CMHC locations throughout Indiana.

Methodology

We selected an unrestricted random sample of 200 services from a population of 3,406,575 MRO services totaling about \$226.5 million (\$144 million Federal share). We reviewed the sampled payments to determine whether applicable Federal and State claiming requirements were met. (See Appendix A for a description of the sampling methodology and results.)

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, guidelines, and the Indiana State plan;
- interviewed Indiana officials and reviewed Indiana's policies and procedures to determine how MRO services were paid by the fiscal agent;
- visited 19 CMHCs for onsite reviews and obtained supporting documentation submitted by mail from 10 additional CMHCs, which included assessments, treatment plans, medication authorizations, admission and service notes, and professional credentials for staff providing MRO services; and
- confirmed that CMHCs were appropriately certified during FY 2003.

We performed the audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Based on a statistical projection of the sample results, we estimate that Indiana overpaid CMHC providers at least \$33,407,323 (\$21,298,841 Federal share) in reimbursement for services provided during FY 2003. Of 200 randomly selected MRO services provided by CMHCs, 64 included one or more payment errors. The errors occurred because the services did not meet Federal and State reimbursement requirements for rehabilitation services. Indiana did not have adequate internal controls to monitor the providers to ensure that rehabilitation services were in compliance with the Centers for Medicare & Medicaid Services' "State Medicaid Manual" (the Manual) and Federal regulations.

The 64 services included 65 payment errors, as follows:

- missing or incomplete documentation for services (58 errors),
- services paid incorrectly by the State's fiscal agent (5 errors),
- ineligible service (1 error), and
- service by a provider who lacked proper credentials (1 error).

DOCUMENTATION ERRORS

For 58 of the errors, included within 57 of the 200 sampled services, the documentation failed to properly support billed services.¹ The Manual, section 4221(D), requires that providers maintain sufficient written documentation to support each service billed. According to the Manual, this documentation, at a minimum, should include setting, amount of time, date, specific services rendered, relationship to the treatment plan, service provider, and updates describing the client's progress.

¹One of the 57 services included two types of documentation errors.

In addition, the Manual, section 4221(C), requires that a treatment plan be included in the patient's medical records. The Manual provides that the treatment plan include the specific medical and remedial services, therapies, and activities that will be used to meet the treatment objectives. Services not included in the treatment plan can be provided and paid for under Medicaid but must adhere to a higher documentation standard set forth in the Manual, section 4221(D).

The following table summarizes the documentation errors that we identified.

Documentation Errors

Type of Error	Number of Errors
Missing or incomplete documentation	45
No treatment plan	13

FISCAL AGENT PAYMENT ERRORS

Indiana's fiscal agent paid for five services at an incorrect payment rate of 100 percent, even though the providers submitted claims for the services with the appropriate payment modifiers. The providers, including resident technicians, caseworkers, and other staff, were not physicians, psychiatrists, or health service providers in psychology. The "MRO Manual" requires that mental health practitioners (other than physicians, psychiatrists, or health service providers in psychology) receive 75 percent of the allowed rate.

INELIGIBLE SERVICE

One service was ineligible because a family member (a foster parent) provided an assisted daily living service, which is in direct violation of the Manual, section 4480. This section precludes a family member (such as a parent) from receiving reimbursement for providing personal care services, such as services for assisted daily living. The IAC (470 IAC 3.1-1-13.5) defines a foster parent as ". . . person(s) who have an ongoing, long term parental relationship with the child; (2) are willing to make the decisions required of parents; and (3) have no interest that would conflict with the interests of the child."

STAFFING CREDENTIALS

The provider of one service did not hold the appropriate credentials in accordance with the IAC. Although this provider met the qualifications of a case manager, the provider was not licensed and did not meet the educational requirements. The IAC (405 IAC 5-20-8(2)) allows outpatient mental health services for individual outpatient psychotherapy only:

. . . when such services are provided by one of the following practitioners:

- a licensed psychologist;
- a licensed independent practice school psychologist;

- a licensed clinical social worker;
- a licensed marital and family therapist;
- a licensed mental health counselor;
- a person holding a master's degree in social work, marital and family therapy, or mental health counseling; or
- an advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

A case manager consequently does not qualify as a practitioner.

RECOMMENDATIONS

We recommend that Indiana:

- refund \$21,298,841 to the Federal Government and
- strengthen internal controls over the monitoring of MRO services by furnishing written notification to CMHC providers reminding them to prepare and retain complete documentation to fully support Federal and State claiming provisions.

INDIANA'S COMMENTS

In written comments on our draft report, Indiana agreed with our second recommendation and partly agreed with our first recommendation. Indiana agreed that the fiscal agent overpaid sampled claims due to system programming errors and that recovery of overpayments is needed; however, it requested that we exclude these errors from our sample results and statistical projection because it was aware of the problem before the audit period. Indiana also submitted additional information and requested further reconsideration of specific claims. Indiana's comments are included as Appendix B. We have not included the attachments to the comments because of their length but will provide them on request.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We analyzed the additional documentation and determined that the majority of the documentation had been reviewed during fieldwork. However, based on our review of Indiana's comments, we accepted six services—four documentation errors and two ineligible services—and revised the projected refund and final report as appropriate. We did not exclude the fiscal agent payment errors from our projection because the claims were paid in 2003, and Indiana indicated that a system change order to correct the programming errors had been waiting for the necessary resources to resolve the issue. Consequently, Indiana had not initiated recovery of the overpayments.

APPENDIXES

SAMPLING METHODOLOGY AND RESULTS

POPULATION

The population consisted of 3,406,575 paid service line items for Medicaid Rehabilitation Option (MRO) services provided by community mental health centers during Federal fiscal year 2003.

SAMPLE DESIGN

We selected an unrestricted random sample of 200 MRO service line items.

RESULTS OF SAMPLE

The results of the sample review are presented below:

Population	Sample Size	Number of Samples With Overpayments	Federal Share of Overpayments
3,406,575	200	65	\$1,685

We used the Office of Inspector General, Office of Audit Services RAT-STATS variable appraisal program for unrestricted random samples to project the sample results.

The point estimate of the projection of the Federal share of overpayments was \$28,697,883. At the 90-percent confidence level, the lower limit of the projection was \$21,298,841, and the upper limit was \$36,096,924.



*"People
helping people
help
themselves"*

Mitchell E. Daniels, Jr., Governor
State of Indiana

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

November 28, 2006

Mr. Paul Swanson
Regional Inspector General for Audit Services
Office of Audit Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 1360
Chicago, Illinois 60601

Re: Response to Draft Report A-05-05-00057

Dear Mr. Swanson:

In response to draft audit report "Review of Medicaid Community Mental Health Center Provider Services in Indiana," the Office of Medicaid Policy and Planning (OMPP) reviewed the findings for services claimed under the Medicaid Rehabilitation Option (MRO) by the Community Mental Health Centers (CMHCs). The response to the recommendations are noted below. An attachment with specific detail is also included.

OIG Audit Recommendation: refund \$23,262,717 to the Federal Government

This recommendation was based on a random sample claim review of 200 services for the MRO program billed by CMHCs within Indiana. In developing the extrapolated overpayment, the OIG identified claim specific errors that were categorized into five general categories. These categories are separately addressed to discuss their distinct justification.

Documentation Errors:

The OIG noted errors predominantly due to missing or incomplete documentation for services.

The OMPP agrees that the State Medicaid Manual requires that providers maintain sufficient written documentation to support each service billed. The first opportunity for the State to assist in the collection of the documentation came during the review of this draft report. During the audit process, the OIG team requested documentation directly from the CMHCs. Upon receipt of the report, the OMPP directed Health Care Excel (HCE), the Surveillance and Utilization Review (SUR) contractor for the state, to conduct



onsite visits to each of the CMHCs to assist with a secondary search for the needed documentation. HCE requested full, complete files for each member whose service data was either missing or incomplete. Requesting documentation in this manner can result in a greater record recovery percentage due to many additional volumes of files being examined. Misfiling may occur during regular business operations making post-audit review difficult. As a member's file ages the ability to maintain historical, chronological data may also weaken, further complicating the recovery process. However, through this secondary search additional information was located. The attached spreadsheet noted as Attachment A details when, and how additional or missing documentation was located for each CMHC.

The OIG also found errors due to the lack of a treatment plan submitted for review. In several instances, additional supporting documentation was located. This documentation supports the physician oversight requirement of 405 IAC 5-21-6, which states that the supervising physician or Health Service Provider in Psychology (HSPP) must see the patient, or review the treatment plan submitted by the qualified mental health professional at intervals not to exceed ninety (90) days. As a treatment plan update signed by the physician, or a medical note signed by the physician within the 90 day time frame provision was located for each, OMPP believes that there was sufficient documentation to support the requirement for physician oversight. This conclusion is explained in Attachment A.

In those cases that the OIG argued that a service was not covered under the member's treatment plan, additional review was conducted. A treatment plan must include treatment directed goals, and specific treatment modalities and services that will be provided to a client. In a few cases, either a treatment plan, or an update was located which authorized the disallowed service(s). This conclusion is explained in Attachment A.

The supporting documentation is provided in full in Attachment D by sample number for your review.

Fiscal Agent Payment Errors:

Five errors were cited due to services paid incorrectly by the State's fiscal agent.

OMPP State staff was aware of the system's failure to cut back to a reduced reimbursement rate for mid-level practitioners that caused the payment errors noted in this report. In addition, a change order (CO) to correct the issue has been waiting for the necessary resources to resolve the system issue. The system logic will be re-programmed to increase the number of modifiers that are recognized by the system for processing. By capturing all four processing modifiers, claims will process appropriately. This CO is currently being worked by the fiscal agent with detailed requirements already written.

Upon completion of the change order, there will be a mass adjustment for all claims inappropriately processed at one hundred percent. Providers are aware that this additional money will be recovered upon completion of the system change. This is anticipated to be

completed within the second quarter of 2007. OMPP believes that appropriate claim specific recovery is needed, however as this was identified prior to the audit period, believes that these claims should be excluded from the extrapolation process. Claims noted for this issue are included in Attachment B.

Lack of Direct Patient Care:

In some instances, OIG determined that the services billed were not directly related to the care of the patient.

In review of these patients' charts, OMPP believes that in four cases there was evidence to support a direct patient care activity that was supported by the patient's treatment plan. The rationale for each is detailed in the attachment.

Ineligible Services:

The OIG disallowed services related to MRO services provided in a nursing home setting. This preliminary finding was made pursuant to Section 4320(D) of the State Medicaid Manual and 42 CFR 440.90 for clinic services. It seems that the OIG findings are based upon the understanding that MRO services are provided under the federal "clinic" option, when these services are actually provided under the "rehabilitative services" option directed by 42 CFR 440.130.

The State Medicaid Manual prohibits clinic services from being provided on-site in nursing homes. By definition, clinic services are provided to "outpatients," thus nursing home residents can only receive clinic services at the clinic or some other setting that does not provide continuous 24-hour care. However, Medicaid Rehabilitation Option services in Indiana are not provided under the optional clinic category. While some rehab services are provided under the clinic option in Indiana, MRO services are provided under the rehab option (42 CFR 440.130), which is a separate optional federal benefit under the approved State Plan. Indiana's State Plan notes MRO services are provided under "Other diagnostic, screening, preventive, and rehabilitative services". This section title mirrors the section heading for 42 CFR 440.130, which is a separate section from the optional clinic services provision. See Attachment 3.1-A, page 6, item 13.d and Addendum 3.1A, item 13.d1, pages 8-10 of Indiana's approved State Plan which clearly note MRO services are provided under the rehabilitative services optional category.

Rehab services can be provided in a variety of settings. The rehab aspects of some services, such as outpatient hospital and clinic services are specifically included in the definition of those services in Medicaid regulations. Federal regulations also afford states the ability to provide rehab services as a separate optional benefit (see 42 CFR 440.130). 42 CFR 440.130 does not limit the provision of rehab services to the "outpatient" setting. Indiana's approved State Plan notes community mental health rehab services are provided in the "home, work place, mental health facility, emergency room, or wherever urgently needed," under the optional rehabilitative services category. Thus, Indiana has authority under federal regulations and our state plan to reimburse providers for MRO services provided in the nursing home setting to residents of nursing homes. Claims specifically cited for this concern are noted in Attachment C.

Staffing Credentials:

The OIG noted that for one service the provider did not hold the appropriate credentials.

OMPP does not dispute this finding.

Upon your additional review of the attached documentation and supporting evidence of services, OMPP believes that further reconsideration of the recoupment total is appropriate. Specifically, of the total \$1,805.44 the OIG cited through the sample claim review, \$859.52 should be removed from the claim specific overpayment value and therefore the extrapolated overpayment should be revised.

OIG Audit Recommendation: strengthen internal controls over the monitoring of MRO services by furnishing written notification to CMHC providers reminding them to prepare and retain complete documentation to fully support Federal and State claiming provisions

OMPP has taken many opportunities to educate and engage the CMHC providers regarding the need to fully support the Federal and State claiming provisions. HCE staff attends quarterly meetings specifically to discuss issues noted by providers regarding the Medicaid Rehabilitation Option program. This meeting provides an opportunity for providers to have questions addressed by the audit contractor, as well as listen to feedback from HCE regarding findings and the audit process. HCE regularly addresses the requirement to maintain full documentation for services rendered in this forum.

Annually, provider workshops are held. At least one presentation describes the purpose and process of OMPP auditing programs. It is reaffirmed that the auditing programs ensure that all Medicaid requirements are consistently, accurately held to by Indiana providers as contracted through the provider agreement that they signed upon enrollment. This agreement details the requirements specified in 405 IAC 1-5 and in the *Indiana Health Coverage Programs Provider Manual*. Through the auditing process itself, providers are also provided written notification regarding the requirement to maintain documentation.

Additionally, a bulletin (BT032006) was developed and sent to the CMHC providers expressly to provide recommendations regarding developing internal review programs. This bulletin lists essential parts of the individual's medical record to support billed services.

OMPP believes that these measures address the recommendation, and will continue to fulfill this obligation through the methods noted above. However, as a result of this audit OMPP has noted that additional work needs to be done. Clarifications surrounding the service level definitions are needed. These definitions will be reviewed and the manual revised to include this information, as well as ensure clear documentation requirements are incorporated.

Thank you for the opportunity to address these concerns through this review process. Should you have questions regarding this response, or require additional information, please contact Catherine Snider at 317-234-2927 for further assistance.

Sincerely,

A handwritten signature in black ink, reading "Jeanne M LaBrecque". The signature is fluid and cursive, with the first name "Jeanne" being the most prominent.

Jeanne M. LaBrecque
Director of Health Policy and Medicaid

JML:cas